REPORTING FORM

Please provide the following information.

Your Name: Phone #: 406-538-7451

Name of Facility: MMHNCC

INITIAL 24 HOUR REPORT

Please provide the following information.

Date of your initial report to the State Agency:

Date of the allegation/injury:

Time of the allegation/injury:

Name of the Resident(s):

Name of the victim (residents):

Name of the aggressor(s):

Brief description of the allegation/injury:

Was medical treatment necessary, if so, what:

The plan to prevent further abuse:

5 DAY INVESTIGATION RESULTS REPORT

Please provide the following information.

Date results sent to the State Agency.

Your name:

Outcome of your investigation:

Email to: MTSSAD@mt.gov Fax to: State Certification Bureau (406)-444-3456 Lewistown Chief of Police, 535-7407; AMDD Administrator (406)-444-4435; State Ombudsman (406)-444-7743; State Board of Visitors (406)-444-3543.